

EXHIBIT 2



May 2012

5 KEY QUESTIONS ABOUT MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS & HEALTH REFORM

Summary

1. What is Medicaid and what does it do?

- Medicaid is the nation's primary health insurance program for low-income and high-need Americans.
- Medicaid is the largest source of funding for safety-net providers and the dominant payer for long-term care. Medicaid also helps to make Medicare work for low-income elderly and disabled beneficiaries.
- States administer Medicaid within broad federal rules and have a lot of flexibility to design their programs.
- Medicaid increases access to care and limits out-of-pocket burdens for low-income people. Most Medicaid enrollees obtain care through managed care arrangements that use private provider networks.

2. What does Medicaid cost and why?

- Medicaid accounts for about one sixth of total health care spending in the country.
- The elderly and disabled account for the majority of Medicaid spending. Medicaid spending is concentrated among a small number of high need enrollees.
- Enrollment is the dominant driver in Medicaid spending, especially during periods of economic downturn.
- On a per enrollee basis, Medicaid spending is growing more slowly than premiums for employer-sponsored insurance or national health care spending overall.

3. What is Medicaid's role in state budgets?

- The Medicaid program is jointly funded by states and the federal government.
- Medicaid is a counter-cyclical program; during economic downturns, individuals lose jobs, incomes drop, state revenues decline, and more individuals qualify and enroll in Medicaid which increases spending.
- Medicaid is the largest source of federal revenue for states. The share of state general fund spending for Medicaid has remained stable over the last decade. Medicaid funds support health care providers, jobs and state economies overall.
- Due to budget pressures over the last decade, states adopted an array of cost containment measures.

4. What is Medicaid's role in the federal budget?

- Medicaid is the third-largest domestic program in the federal budget.
- As a low-income program, Medicaid is exempt from automatic budget reductions included in the Budget Control Act.
- Federal deficit reduction discussions continue to include Medicaid. The House budget plan converts Medicaid to a block grant and repeals the ACA cutting federal Medicaid spending by 38% by 2022.
- Twice during the last decade the legislation was enacted to increase the federal share of Medicaid payments as an economic downturn led to increased enrollment and reduced state revenues.

5. What is Medicaid's role in health reform?

- Health reform builds on Medicaid as a base of coverage for low-income Americans extending coverage to nearly all non-elderly citizens to 133% of poverty.
- According to the CBO, the ACA will reduce the number of uninsured by 30 million in 2016, with an estimated 17 million additional individuals covered by Medicaid.
- The federal government will finance about 95% of the costs of new Medicaid coverage from 2014 to 2019. States could see savings from reduced payments for services currently provided for the uninsured.
- ACA provides new options to expand community-based long-term care and to coordinate care for duals and other high cost populations.

1. What is Medicaid and what does it do?

Medicaid is the nation's primary health insurance program for low-income and high-need Americans. Medicaid covers more than 62 million low-income Americans. The program provides health coverage for low-income families who lack access to other affordable coverage options and for individuals with disabilities for whom private coverage is often not available or not adequate. Today, Medicaid does not cover all individuals with low incomes. Millions of low-income adults (particularly adults without dependent children) are uninsured because they are not eligible for Medicaid and do not have access to other coverage. Given the wide array of health needs and limited incomes of enrollees, Medicaid provides a broad range of services, with limited cost-sharing.

Medicaid is the largest source of funding for safety-net providers and the dominant payer for long-term care.

Medicaid also helps to make Medicare work for low-income elderly and disabled beneficiaries. Medicaid is the largest source of funding for safety-net providers (such as community health centers and public hospitals) that serve the poor and uninsured. Many of these providers are located in low-income communities or rural areas with provider shortages. Medicaid is also the nation's largest payer for long-term care services. It helps to make Medicare work for over 9 million low-income elderly and disabled beneficiaries who rely on Medicaid to help pay for Medicare premiums, gaps in Medicare benefits, and long-term care needs.

States administer Medicaid within broad federal rules. State participation in Medicaid is optional. States that elect to participate, as all have done for the past 30 years, must meet core federal requirements related to coverage and benefits to receive federal matching funds. States have flexibility to cover populations and services beyond federal minimums and receive federal matching funds for these costs. States also have a great deal of flexibility to determine how to deliver care and how much to pay providers. Flexibility to set eligibility levels has been limited over time by increases in federal minimum levels for children and pregnant women and more recently by eligibility protections put in place under the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA). However, as a result of general flexibility there is large variation from one state Medicaid program to the next. Four in ten dollars were spent on federally-required services provided to federal core enrollees in 2007 and the remaining 60% of spending was for state expansion enrollees and optional services. Financing for Medicaid is shared between the states and the federal government, with the federal government paying 57% of Medicaid costs on average across states. For states, Medicaid represents a major budget item and the largest source of federal revenues.

Medicaid increases access to care and limits out-of-pocket burdens for low-income people. Children and adults enrolled in Medicaid have much better access to care than those without insurance. And compared with people who do have private health insurance, Medicaid enrollees fare just as well on most measures of access to preventive and primary care, despite often cited concerns about provider participation. There are issues related to access to some provider types like dentists and some specialists; however, these issues reflect more general provider shortages as well as problems with the geographic distribution of physicians that are not limited to Medicaid. Because the population covered is low-income, Medicaid does not require premiums and imposes little cost sharing, so enrollees face far fewer financial barriers to care compared to the uninsured and many with private insurance. Medicaid's extensive use of managed care arrangements has helped to improve access to care for many of its enrollees.

Although Medicaid is publicly financed, the program purchases health services primarily in the private sector.

Unlike the health system for veterans that is financed and operated by the government, Medicaid programs purchase services on a fee-for-service basis, or by paying premiums to managed care plans under contracts, or by using a combination of both approaches. About two-thirds of Medicaid enrollees are enrolled in some type of managed care (fully capitated plans or primary care case management). These plans use networks of private providers to deliver covered services to their enrollees. Medicaid managed care enrollees are largely children and families, although many states are moving forward to enroll elderly and disabled beneficiaries in managed care plans as well.

2. What does Medicaid cost and why?

Medicaid accounts for about one sixth of total health care spending in the country. Medicaid represents 19% of all hospital spending and 32% of all nursing home spending in the U.S. In fiscal year 2010, total federal and state Medicaid benefits spending (including disproportionate share hospital payments) was \$389 billion. About two-thirds (64%) was spent on hospital, physician, drugs, and other acute care services; about a third (31.5%) was on nursing home and other long-term care services, and the remaining was spending on DSH.

The elderly and disabled account for the majority of Medicaid spending. While children and parents make up about 75% of Medicaid enrollees, they account about a third of the spending. In contrast, the elderly and individuals with disabilities make up about 25% of enrollees but about two-thirds of spending. Medicaid spending per capita in 2009 was \$2,313 for children and \$2,926 for non-disabled adults. Per capita spending for the elderly (\$13,186) and disabled (\$15,453) was about 7 times the per capita spending for children and adults. The elderly and disabled have higher utilization and intensity of use for acute care services and the elderly and disabled are more likely to use long-term care services.

Medicaid spending is concentrated among a small number of high need enrollees. Individuals dually eligible for Medicare and Medicaid represent 15% of Medicaid enrollees and 38% of Medicaid spending, helping these individuals pay for Medicare premiums, and providing services and benefits that Medicare does not, including long-term care. Furthermore, only 5% of all Medicaid enrollees account for over half (55%) of Medicaid spending.

Enrollment is the dominant driver in Medicaid spending, especially during periods of economic downturn.

Medicaid costs are driven largely by increases in enrollment. Inflation in the price of the health care services that Medicaid buys, and the use of services by Medicaid enrollees, also affect Medicaid spending, but enrollment is the dominant driver. This is especially true during economic downturns, when unemployment rises and incomes fall, increasing the number of low-income people eligible for Medicaid. From 2007 to 2010, total Medicaid spending grew by 24% with enrollment growing by 19% and spending per enrollee only increasing by 4%.

States have a strong incentive to manage Medicaid cost growth. Because states pay, on average, 43% of Medicaid costs, and because they must produce annual balanced budgets, states have a strong incentive to carefully manage program spending growth. Over the last decade, states have implemented an array of Medicaid cost containment measures as well as innovative service delivery models (including use of managed care and medical home models) to manage the growth of Medicaid costs.

On a per enrollee basis, Medicaid spending is growing more slowly than premiums for employer-sponsored insurance or national health care spending overall. On a per enrollee basis, Medicaid spending growth is lower than the growth in both employer-sponsored insurance coverage and national health expenditures overall. From 2007-2010, Medicaid spending per enrollee grew an average of 2.5% per year; the comparable rate of growth in the per capita costs of employer-sponsored insurance was 5.5% per year and 3.3% for national health expenditures per capita. Even though Medicaid is growing more slowly than other health programs, Medicaid still uses private providers in the private health care market, so it will take broader efforts that span all payers, both public and private, to bring overall health care costs under control.

3. What is Medicaid's role in state budgets?

The Medicaid program is jointly funded by states and the federal government. The federal matching percentage (FMAP) varies by state (ranging from a statutory floor of 50% up to 74% in 2012) and is based on a formula in the law that relates the FMAP to a state's average personal income. For every \$2 that states pay for a Medicaid-covered service, they receive at least \$1 back from the federal government. By the same token, to save just \$1 in state general fund spending on Medicaid, states need to cut at least \$2 in Medicaid spending.

Medicaid is a counter-cyclical program; during economic downturns, individuals lose jobs, incomes drop, state revenues decline, and more individuals qualify and enroll in Medicaid which increases program spending.

During the recent recession, state revenues experienced record declines and Medicaid enrollment soared. While both contributed to state budget shortfalls, data show that declines in state revenues were a much more significant factor for state budget gaps than increases in Medicaid spending. Looking ahead to state fiscal year 2013, there are some positive economic signs emerging. State revenues are rebounding and the national unemployment rate is trending downward. From October 1, 2008 through June 30, 2011, enhanced Medicaid matching funds from the ARRA were critical in helping to support state budgets and Medicaid. The ARRA temporarily increased the federal share of Medicaid payments and reduced the state share. When these federal funds expired, states saw a large increase in state costs for Medicaid for state fiscal year 2012 putting further pressure on states to control Medicaid costs.

Medicaid is the largest source of federal revenue for states. Medicaid funds support health care providers, jobs and state economies overall. On average, states spend about 16% of their own funds on Medicaid, making it the second largest program in most states' general fund budgets (following elementary and secondary education, which represented 35% of state spending in FY 2010). These shares have remained relatively stable over the last decade. Medicaid matching funds are the single largest source of federal grant support to states (42% in FY 2010). Accounting for this federal revenue, Medicaid is a larger share of state overall budgets (22% in 2010). By bringing revenues to hospitals, nursing homes, clinics, pharmacies, and other providers, Medicaid plays an important role in supporting jobs and economic activity in urban and rural communities alike.

State budget pressure over much of the last decade has resulted in states adopting an array of cost containment measures. During economic downturns, states have restricted provider payment rates and optional benefits for adults as primary responses to controlling Medicaid costs. Over the past decade, states have also made substantial changes to their pharmacy programs by employing a variety of sophisticated pharmacy management tools. In addition, there has been a steady movement toward efforts to better manage care in an effort to both improve care and control costs. States have been expanding managed care to more geographic areas within states and to new populations, including complex populations. States are also working to better integrate care and financing for duals given that they represent such a large share of Medicaid costs. The ARRA and ACA maintenance of eligibility (MOE) protections have largely prohibited states from cutting Medicaid eligibility or from making it more difficult to obtain and maintain coverage.

4. What is Medicaid's role in the federal budget?

Medicaid is the third-largest domestic program in the federal budget. In 2010, spending from Medicaid, Medicare, and Social Security accounted for about 43% of all federal spending (Medicaid accounting for 8% of federal spending, Medicare 15%, and Social Security 20%). Compared to Medicare and Social Security, Medicaid has less impact on the federal budget because financing is shared by the federal government and the states with states paying about 43% of the costs.

As a low-income program, Medicaid is exempt from automatic budget reductions included in the Budget Control Act.

Control Act. In 2011 various proposals were advanced to reduce annual federal deficits and to slow the increase in the national debt. On August 2, 2011, President Obama signed the Budget Control Act of 2011 into law. The Act, passed as the nation was about to breach the debt ceiling, was designed to reduce federal spending and raise the debt ceiling. The Budget Control Act established the Joint Select Committee, also known as the “Super Committee,” tasked with decreasing projected deficits by \$1.5 trillion between FY2012 and FY2021. The Committee had broad authority to propose changes to meet its target, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the budget. In November 2011, the Super Committee issued a statement indicating that they could not come to an agreement on a plan to achieve deficit reduction which means that a sequestration of \$1.2 trillion in federal funds should begin in January 2013. Social Security, Medicaid, and other programs serving low-income individuals are exempt from the sequestration.

Medicaid continues to be discussed as part of federal deficit reduction efforts in 2012. Proposals to reduce federal Medicaid spending advanced by the President, Congress and various deficit reduction commissions over the last few years varied significantly in the scope and magnitude of the changes involved. Some proposals would fundamentally change the structure and financing of Medicaid, with major implications for providers and beneficiaries. The budget plan passed in the House in 2011 and again in 2012 would convert Medicaid into a block grant. The plan would cap federal Medicaid payments to each state at a specified dollar amount and limit program growth below the levels at which Medicaid is now expected to grow based on enrollment and health care inflation to save money. Some cite additional flexibility for states under capped financing, but have not been specific on what new flexibility would be granted and what federal standards would remain in place as a condition for receipt of federal funds. Under a block grant, costs that the federal government would otherwise have shared could be shifted to states, counties, providers, or low-income people. The House plan would also repeal the ACA. Accounting for the block grant and the repeal of the ACA, the CBO estimates that House budget plan would reduce Medicaid spending by 38 percent by 2022. The President’s budget proposal for FY 2013 included about \$60 billion over the next ten years in federal Medicaid savings. Proposals include limitations on Medicaid provider taxes, a blended match rate for Medicaid and the Children’s Health Insurance Program, limiting reimbursement for durable medical equipment and accounting for the continuation of lower disproportionate share hospital payments after 2021. Other proposals advanced over the last few years include shifting duals to managed care, or program swaps (such giving the states and the federal government responsibility for financing and administration of certain parts of Medicaid such as acute care and long-term care, or certain populations).

Twice during the last decade the legislation was enacted to increase the federal share of Medicaid payments during an economic downturn to support the program and the states. In general, Medicaid is a counter-cyclical program. During economic downturns, individuals lose jobs, incomes drop, state revenues decline, and more individuals qualify and enroll in Medicaid which increases program spending. The current FMAP formula, which relies on lagged data, is not adequate to make timely adjustments for changes in economic conditions that increase Medicaid enrollment while reducing state revenues that finance the program. For this reason, through the ARRA and one other time in 2003-2004, Congress enacted legislation to provide federal program support and fiscal relief through Medicaid. The Administration has advanced a proposal that would call for an automatic increase in the FMAP if a recession forces enrollment and State costs to rise beginning in 2017.

5. What is Medicaid's role in health reform?

Health reform builds on Medicaid as a base of coverage for low-income Americans. The Patient Protection and Affordable Care Act (ACA) will extend health insurance coverage to millions Americans through Medicaid and new health insurance exchanges. By 2016, an estimated 17 million are expected to newly enroll in Medicaid. The ACA sets a national floor for Medicaid eligibility at 133% of poverty (FPL) (\$14,856 per year for an individual in 2012), bases eligibility on income, without regard to assets, and transitions to a uniform definition of income. These changes will primarily expand Medicaid coverage for adults (parents with limited Medicaid eligibility levels in many states and adults without dependent children who have been historically barred from Medicaid coverage). Medicaid along with tax credits for individuals with incomes between 133% and 400% of poverty to purchase coverage in new insurance exchange will help reduce the number of uninsured by 30 million in 2016. The US Supreme Court will consider several issues related to the constitutionality of the ACA including the individual mandate and the Medicaid expansion.

The federal government will finance about 95% of the costs of new Medicaid coverage from 2014 to 2019. The ACA provides 100% federal financing for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal share to 90% by 2020 and beyond. States will continue to receive their regular matching rates for individuals who qualify for Medicaid under eligibility rules in place when ACA was enacted. Some states that already cover childless adults will receive a phased-in increase in their match rate for this population. New state spending for Medicaid coverage may be offset by savings from reduced state payments for uncompensated care and other services (like mental health) currently provided for the uninsured. Over the 2014-2019 period, the federal government is expected to finance about 95% of the costs of the new Medicaid coverage. States could see savings from reduced payments for uncompensated care or other payments for services for the uninsured (like mental health services). Some states may be able to transition coverage for individuals with incomes above 133% of poverty from Medicaid to the new insurance exchanges to achieve savings.

Like today, most Medicaid enrollees will likely access care through private managed care plans. The benefits for those newly eligible for Medicaid must, at a minimum, match the essential health benefits required for coverage available through the Exchanges, but will not include some services covered in the traditional Medicaid package like long-term care services. In an effort to boost provider participation and access, the ACA increases Medicaid payments for primary care services provided by primary care physicians to 100% of the Medicare payment rates for two years, with full federal financing for the increased costs. Health reform also includes significant investments in community health centers, which have long been an important source of access to care for Medicaid enrollees and other low-income individuals. Because Medicaid purchases services in the private health care market, current national shortages in the supply of physicians and problems with the geographic distribution of physicians, will affect access for individuals with Medicaid and private coverage as the ACA is implemented.

ACA provides new options to expand community-based long-term care and to coordinate care for high cost populations. ACA also includes a number of other changes to Medicaid including new options to expand community-based long-term care, new funding for demonstration programs, and new opportunities for states to test innovative payment and delivery systems and to coordinate care for dual eligibles. Through the new Medicare-Medicaid Coordination Office 15 states receive \$1 million planning contracts to design innovative approaches to integrate and coordinate care for dual eligibles and 38 states submitted a letter of intent to pursue other delivery system and payment models for duals where states could share in potential savings.

See 5 Key Questions and Answers about Medicaid Chartpack <http://www.kff.org/medicaid/8162.cfm>

This publication (#8139-02) is available on the Kaiser Family Foundation's website at www.kff.org.